



August 29, 2023

The Honorable Chiquita Brooks-LaSure
Administrator, Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
Attention: CMS-1780-P
P.O. Box 8013
7500 Security Boulevard
Baltimore, MD 21244-8013

RE: CY 2024 Home Health Prospective Payment System Rate Update; Home Health Quality Reporting Program Requirements; and Home Intravenous Immune Globulin (IVIG) Items and Services

Dear Administrator Brooks-LaSure:

On behalf of the American Speech-Language-Hearing Association (ASHA), I write to offer comments on the home health prospective payment system (PPS) related provisions within the above referenced proposed rule and requests for information.

ASHA is the national professional, scientific, and credentialing association for 228,000 members and affiliates who are audiologists; speech-language pathologists; speech, language, and hearing scientists; audiology and speech-language pathology assistants; and students. Audiologists specialize in preventing and assessing hearing and balance disorders as well as providing audiology treatment, including hearing aids. Speech-language pathologists (SLPs) identify, assess, and treat speech, language, swallowing, and cognitive-communication disorders.

Many ASHA members who are speech-language pathologists (SLPs) treat patients receiving services through a home health agency and, as a result, have a vested interest in ensuring the regulatory and payment policies are appropriate for Medicare beneficiaries to have access to this critical level of care.

II. Home Health Prospective Payment System
C. Proposed Provisions for CY 2024 Payment Under the HH PPS

In the rule, the Centers for Medicare and Medicaid Services (CMS) proposes to reduce payments to home health agencies in 2024 by 5.1% which is offset by the market basket increase of 2.7% for a total reduction to the industry of 2.2%. It continues its analysis that began in 2020, after implementation of the patient driven groupings model (PDGM), to determine if its assumptions regarding potential behavior changes on the part of agencies and program spending were accurate. CMS has subsequently found that service delivery, particularly for therapy services, has decreased more dramatically than it anticipated and that overall payment for home health services exceeds cost by approximately 45%.

ASHA recognizes that it is important to pay accurately and adequately for services to maintain access to care for Medicare beneficiaries and protect the Medicare trust fund. We share CMS's concerns regarding the dramatic reduction in therapy service delivery and the significant

difference between cost and payment. But we are alarmed that the provisions of the rule do not include a discussion of the impact of these service delivery reductions on quality of care. While spending may have increased, what impact has the higher payment and lower therapy provision had on patient outcomes, quality of life, and independence?

ASHA remains concerned that the picture coming into focus is a significant imbalance between therapy provision and more clinically complex patients. In the rule, CMS highlights that home health patients' functional impairment levels are higher than anticipated and the number of patients with comorbidities has also increased while therapy visits have dramatically decreased. Before cutting payment, ASHA requests that CMS identify if this imbalance has had negative consequences for patients and their outcomes. If it has, a blunt payment reduction could further erode access to needed care for Medicare beneficiaries and inadvertently reduce the quality of this care.

Instead, we request that CMS consider what mechanisms it has at its disposal to identify problematic, and potentially fraudulent, actions taken by bad actors within the home health industry. For example, OASIS item M2220 captures therapy delivery. If a home health agency has received a therapy payment but no therapy has been delivered, the medical record should be reviewed to determine if there was a clinical rationale for not delivering therapy. In absence of a clinical rationale for withholding therapy, CMS should recoup the therapy payment provided to the home health agency.

Additionally, ASHA members report that therapy provision is increasingly dictated by algorithms and administrative mandates, not the clinical judgment of the multidisciplinary care team. Anecdotally, our members report that they are only given a handful of visits by the home health agency before the patient is discharged from the Part A benefit only to be picked up by the agency under Part B. This could indicate an inappropriate trend in which select home health agencies are shirking their Part A obligations to achieve higher reimbursement under Part B. An analysis of Part B claims submitted by home health agencies should be conducted to determine if there has been a general rise in home health agencies' billing services under Part B since implementation of PDGM. If this trend is confirmed, either generally or by specific companies, CMS should determine if a probe and educate or similar review can be done to ensure home health agencies are aware of and in compliance with Medicare requirements.

ASHA is not convinced that a blunt, across-the-board payment reduction to the industry that fails to account for the impact on quality of care is in the best interest of Medicare beneficiaries or the trust fund. Instead, a thoughtful approach should be undertaken, driven by data from claims and the OASIS that accounts for the impact on quality.

III. Home Health Quality Reporting Program (HH QRP)

D. HH QRP Quality Measure Proposals Beginning with the CY 2025 HH QRP

COVID-19 Vaccination Coverage among Healthcare Personnel (HCP COVID-19 Vaccine) Measure

On May 1, 2023, the White House announced that COVID-19 vaccine requirements for federal employees, federal contractors, and international air travelers would end on May 11, the same day the federal public health emergency ended. In addition, the Departments of Health and Human Services (HHS) and Homeland Security (DHS) announced they will begin the process of ending their vaccine requirements for Head Start educators, health care facilities certified by CMS, and certain noncitizens at the United States land border. ASHA requests that CMS clarify that the elimination of vaccine "mandates" will not impact the adoption or use of the proposed

COVID-19 Vaccination Coverage among Healthcare Personnel (HCP COVID-19 Vaccine) measure.

Discharge Function Score (DC Function) Measure

We agree that determining if improvement or maintenance of function has occurred upon discharge from a post-acute episode of care is critically important to ensure Medicare beneficiaries are getting quality care and achieving the outcomes they require to move on to the next level of care. To that end, CMS proposes to replace the Application of Percent of Long-Term Care Hospital Patients with an Admission and Discharge Functional Assessment/a Care Plan That Addresses Function (Application of Functional Assessment/Care Plan) and the Application of the IRF Functional Outcome Measures: Change in Self-Care Score for Medical Rehabilitation Patients (Change in Self-Care Score) measure; and the Change in Mobility Score for Medical Rehabilitation Patients (Change in Mobility Score) measure with the Discharge Function Measure.

While mobility and self-care are critical elements of function, ASHA maintains our longstanding concern that Section GG of the Outcome and Assessment Information Set (OASIS) and the measures associated with function that CMS has adopted and proposed to date are insufficient to capture all associated functional domains including communication and cognition. An incomplete assessment of holistic functions does not adequately capture the outcomes required for safety and independence. We remain committed to assisting CMS and post-acute care providers, such as home health agencies, to address all domains of function.

III. Home Health Quality Reporting Program (HH QRP)

1. Principles for Selecting and Prioritizing HH QRP Quality Measures and Concepts Under Consideration for Future Years: Request for Information (RFI)

2. Guiding Principles for Selecting and Prioritizing Measures

CMS includes a request for information on the availability of cognitive function measures outside of the home health quality reporting program (QRP) that may be available for immediate use or that may be adapted or developed for use in the home health QRP, using the Brief Interview of Mental Status (BIMS), Confusion Assessment Method (CAM©), PROMIS Cognitive Function short forms, PROMIS Neuro-QoL, or other instruments. In addition, CMS seeks input on the feasibility of measuring improvement in cognitive function during a home health episode; the cognitive skills (e.g., executive functions) that are more likely to improve during a home health episode; conditions for which measures of maintenance—rather than improvement in cognitive function—are more practical; and the types of intervention that have been demonstrated to assist in improving or maintaining cognitive function.

ASHA appreciates CMS's continued commitment to developing assessment tools and quality measures that reflect the full range of illnesses and injuries that home health patients may experience, including those that impact cognition. However, we have long maintained that the BIMS is insufficient and encouraged CMS to identify a different way to capture cognitive function. The primary challenges to adopting a different instrument remain the proprietary nature of many cognitive assessment tools and the length of such tools, which leads to concerns about administrative burdens. Despite these barriers, ASHA looks forward to continuing to work with CMS to identify a replacement as soon as practicable.

The BIMS was developed to screen for the presence or absence of a cognitive impairment by assessing only very basic elements of cognition (e.g., attention, short-term memory, verbal interaction), not to diagnose or to track change. BIMS is an insufficient method for assessing

cognition because it does not capture deficits related to executive functioning, judgment, reasoning, and other higher level cognitive functions, which are crucial for safety and community reintegration.ⁱ The scale is too limited to be used to track changes with sufficient sensitivity and shows low sensitivity identifying those cognitive deficits that impact community placement.ⁱⁱ In addition, the constructs being measured by the data elements are not the constructs that are typically the focus of therapy. For example, if short-term memory is impaired, SLPs will likely determine which compensatory strategies are needed to facilitate the patient's functioning given their memory impairment and teach the patient and family members how to best employ these strategies. One would not expect the patient's BIMS score to improve with treatment; thus, the BIMS would be a very poor choice of data elements by which to measure outcomes. ASHA maintains that none of the BIMS data elements should be used to assess the patient's functional status at any point during the episode of care to determine if there was an improvement in that status.

III. Home Health Quality Reporting Program (HH QRP)

E. Form, Manner, and Timing of Data Submission Under the HH QRP

3. Data Elements Proposed for Removal From OASIS–E

CMS proposes to eliminate OASIS item M2220 (Therapy Needs) from the assessment tool. While ASHA appreciates CMS's efforts to minimize administrative burden, we cannot support the removal of this item.

While therapy needs do not drive Medicare payment to home health agencies under the PDGM, a patient's therapy needs still trigger an additional payment if they fall into one of the case-mix groups that are tied to therapy delivery (specifically musculoskeletal and neuro/stroke rehabilitation) and the home health agency receives this therapy payment regardless of whether or not therapy is actually delivered.

CMS has expressed concern regarding a drop in therapy provision since the implementation of PDGM and ASHA shares this concern. While the patient's clinical characteristics and needs should drive payment—not the amount of services provided—ensuring patients receive the care they need and CMS pays for is critically important. Removing this item removes an important mechanism for protecting Medicare beneficiaries and the Medicare trust fund. By maintaining this item, CMS can track when a therapy payment is made, when therapy is not provided, and determine if there was a clinical rationale for not providing therapy services.

Anecdotally, some ASHA members report they are told by their employers that they are not "allowed" to provide therapy services in line with a plan of care the multidisciplinary care team has developed. For example, an SLP may believe that two sessions a week for 6 weeks is appropriate or that such sessions should be for a specified length, such as 30 minutes. However, they are told by their administrator they get five total sessions during the episode or that sessions can only be 15 minutes long. By tracking this data through the OASIS, CMS will be able to identify such trends, although imperfectly. Without it, only post-payment medical record reviews will illuminate true access to therapy care for patients.

A similar approach to tracking therapy provision was adopted by the CMS team responsible for overseeing the skilled nursing facility prospective payment system (SNF PPS)—the patient driven payment model (PDPM). Even though the minutes of therapy provided to SNF residents no longer drives payment, the Minimum Data Set (MDS) still captures the minutes of therapy provided as an important check on SNFs.

For these reasons, ASHA recommends CMS maintain OASIS item M2220.

III. Home Health Quality Reporting Program (HH QRP)

G. Health Equity Update

ASHA supports CMS's framework for health equity and looks forward to development of improved data collection, public reporting and incentives for closing equity gaps, and equity-focused performance metrics and quality improvement initiatives to further this goal.

IV. Proposed Changes to the Expanded Home Health Value-Based Purchasing (HHVBP) Model

B. Proposed Changes to the Applicable Measure Set

2. Proposal to Jointly Replace the OASIS-Based TNC Self-Care and TNC Mobility Measures With the OASIS-Based Discharge Function Score Measure Beginning CY 2025

As stated in our above comments on HH QRP, ASHA is concerned with the Discharge Function Score (DC Function) Measure. Determining if improvement or maintenance of function has occurred upon discharge from a post-acute episode of care is critically important to ensure Medicare beneficiaries are getting quality care and achieving the outcomes they require to move on to the next level of care. While mobility and self-care are critical elements of function, ASHA reiterates our longstanding concern that Section GG of the Outcome and Assessment Information Set (OASIS) and the measures that CMS has adopted and proposed to date associated with function are insufficient to capture all associated functional domains including communication and cognition. An incomplete assessment of holistic functions does not adequately capture the outcomes required for safety and independence. ASHA remains committed to assisting CMS and post-acute care providers, such as home health agencies, to address all domains of function.

Thank you for your attention to our comments. If you have questions regarding the OASIS, including the request for information on selecting quality measures for future years and the removal of specific items, or the annual payment update please contact Sarah Warren, MA, ASHA's director for health care policy for Medicare at swarren@asha.org. If you have questions regarding health equity, the quality reporting program, or the value-based purchasing program please contact Rebecca Bowen M.A. CCC-SLP, PNAP, ASHA's director of value-based care and innovation, at rbowen@asha.org.

Sincerely,



Robert M. Augustine, PhD, CCC-SLP
2023 ASHA President

ⁱ Navathe, A.S., Liao, J.M. Aligning Value-Based Payments With Health Equity: A Framework for Reforming Payment Reforms. *JAMA*. 2022;328(10):925–926. doi:10.1001/jama.2022.14606.

ⁱⁱ Pluck, G., Barajas, B.M., Hernandez-Rodriguez, J.L., & Martínez, M.A. Language ability and adult homelessness. *International journal of language & communication disorders*, 55(3), 332–344. <https://doi.org/10.1111/1460->

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